SPECIAL MEETING OF THE
AOA HOUSE OF DELEGATES

OCTOBER 2020 MEETING
AD HOC - RESOLUTION ROSTER
As of September 24, 2020

HOUSE OF DELEGATES’ REFERENCE COMMITTEE DESCRIPTION:

- Ad Hoc Committee (600 series)
  This reference committee reviews and considers materials relating to physician practice issues, affiliate dynamics, insurance and communications activities.

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RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H600-A/15 DISSEMINATION OF PUBLICATIONS IN OSTEOPATHIC RESEARCH

The American Osteopathic Association will widely disseminate publications, research, and evidence based medicine regarding Osteopathic Medicine and Osteopathic Manipulative Treatment (OMT) and its anatomical and physiological basis to the greater public via prominent, designated public information sites, social networking, public information releases, websites, and other media.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau of Osteopathic Education recommends that the following policy be SUNSET.

(Old language is crossed out and new language is in CAPS)

H601-A/15  REDUCTION OF OSTEOPATHIC TRAINING POSITIONS IN POST-GRADUATE MEDICAL EDUCATION

The American Osteopathic Association will work to create parity in reimbursement from the Centers for Medicare and Medicaid Services (CMS) for all osteopathic training to be equivalent to allopathic programs. 2015.

Explanatory Statement: Submitted by Author
The AOA no longer separately accredits graduate medical education programs.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ______________________________
DATE ______________________________
SUBJECT: H602-A/15 REIMBURSEMENT FOR PHYSICIAN TIME SPENT OBTAINING PRE-CERTIFICATION AND PRE-AUTHORIZATION

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be SUNSET.

(Old language is crossed out and new language is in CAPS)

H602-A/15 REIMBURSEMENT FOR PHYSICIAN TIME SPENT OBTAINING PRE-CERTIFICATION AND PRE-AUTHORIZATION

The American Osteopathic Association will include in its work plan investigation and recommendations for a framework for diagnostic and procedure coding, along with associated payment policies, for physician time spent obtaining required Medicare pre-certifications or pre-authorizations for those designated services or prescriptions and provide a template for use by state affiliates for third party payers within the jurisdiction of their state. 2015

Explanatory Statement: Submitted by Author:
The Bureau of Socioeconomic Affairs has submitted a resolution for consideration by the 2020 HOD which will merge this policy with several other existing policies to create one comprehensive policy addressing Prior Authorization.

Background Information: Provided by AOA Staff
Current AOA Policy:
H343-A/13 CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE FOR PRIOR AUTHORIZATION
H640-A/16 PRIOR AUTHORIZATION
H632-A/17 PRIOR AUTHORIZATION
H635-A/19 PRIOR AUTHORIZATION – PATIENT AUTHORIZATION

Prior HOD action on similar or same topic: H343-A/13 policy reaffirmed in 2013 (referred to BSA in 2018); H640-A/16 policy approved in 2016; H632-A/17 policy approved in 2017, H635-A/19 policy approved in 2019

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT:          H604-A/15  PAY FOR PERFORMANCE

SUBMITTED BY:    Bureau of Socioeconomic Affairs

REFERRED TO:     Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H604-A/15  PAY FOR PERFORMANCE

In an effort to support the establishment of REASONABLE PAYMENT appropriate pay-for-performance methodology that will reflect the quality of care provided by physicians and improve patient health outcomes, the AOA adopts the following principles on quality reporting and pay-for-performance (2006; reaffirmed 2011; revised 2015).

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE _____________________
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H606-A/15 PROPER BADGE IDENTIFICATION OF EMPLOYEES IN A HOSPITAL SETTING

The American Osteopathic Association encourages all healthcare providers and hospital employees to wear hospital-issued identification badges with clear delineation of their professional role and that they verbally introduce and identify themselves and their role in the patient's treatment process, with the overall goal of improving patient safety and patient communication. 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H607-A/15 INTEROPERABILITY OF HEALTH INFORMATION TECHNOLOGY

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H607-A/15 INTEROPERABILITY OF HEALTH INFORMATION TECHNOLOGY

The American Osteopathic Association (AOA) supports A NEW RISK-BASED OVERSIGHT FRAMEWORK FOR CLINICAL SOFTWARE, DEVELOPED THROUGH A MULTI-STAKEHOLDER CONSENSUS-BASED PROCESS. THE FRAMEWORK SHOULD TAKE INTO ACCOUNT RISK RELATIVE TO INTENDED USE, COST/BENEFIT OF PROPOSED OVERSIGHT, AND THE PRINCIPLE OF SHARED RESPONSIBILITY. PATIENT SAFETY AND APPROPRIATE IMPROVEMENTS IN QUALITY, EFFECTIVENESS, AND EFFICIENCY OF CARE DELIVERY SHOULD BE PARAMOUNT. THIS FRAMEWORK SHOULD NOT CONFLICT WITH OR DUPLICATE THE MEDICAL DEVICE REGULATION FRAMEWORK. THE AOA DOES NOT SUPPORT DATA BE TREATED AS A MEDICAL DEVICE, REGARDLESS OF THE CATEGORY OF HEALTH IT ASSOCIATED WITH THE DATA. THE AOA SUPPORTS A NATIONAL NETWORK FOR REPORTING PATIENT SAFETY EVENTS AND OTHER INFORMATION VITAL TO PUBLIC HEALTH, WHERE DATA CAN BE ACCESSED, ANALYZED, AND COMMUNICATED IN A TIMELY MANNER. THE REGULATORY FRAMEWORK SHOULD PROMOTE AN open interoperability platform for health care delivery, in order for clinical information systems to capture and share quality, outcome, cost, AND PATIENT HEALTHCARE data TO SUPPORT COORDINATED HEALTH CARE AND DATA ANALYTICS TO PROMOTE TRANSITION TO A VALUE-BASED HEALTHCARE SYSTEM. THE AOA SUPPORTS A COMMON DATA STRUCTURE THAT WILL ENABLE INTEROPERABILITY, SETTING A CLEAR COURSE OF ACTION, FEDERAL SUPPORT FOR AN EXCHANGE INFRASTRUCTURE, AND STANDARDS WITH WILL MAKE IT EASIER TO SHARE INFORMATION SO PHYSICIANS AND PATIENTS CAN MAKE INFORMED DECISIONS.

The AOA will encourage public and private sector stakeholders to develop clinically driven, standardized products that are interoperable by design, do not require costly and time-consuming customization, and for which any upgrades or future needs can be integrated seamlessly without burdensome costs or system modifications. The AOA also supports standardization of prior authorization attachments to alleviate burden and reduce delays to care.

The AOA opposes vendors blocking health care professionals’ ability to access, view, share, or transfer data.
The AOA supports policies and technologies that facilitate person-centered health care, not technology-centered healthcare and policies that include adequate positive incentives for the adoption of health information technology.

The AOA will remain vigilant about mitigating the level of administrative burden posed by existing and new government policies. 2015

Explanatory Statement: Submitted by Author
This policy merges with H603-A/19 titled REGULATION OF HEALTH INFORMATION TECHNOLOGY SOFTWARE and includes content provided by the Michigan Osteopathic Association. Upon approval of this resolution policy H603-19 will be sunset.

Background Information: Provided by AOA Staff
Current AOA Policy: H603-A/19 titled REGULATION OF HEALTH INFORMATION TECHNOLOGY SOFTWARE

Prior HOD action on similar or same topic: Policy reaffirmed as amended in 2019.

FISCAL IMPACT: $0

ACTION TAKEN _______________________

DATE ____________________________
RESOLVED, that the Ethics Subcommittee recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H612-A/15 GIFTS TO PHYSICIANS FROM INDUSTRY

The American Osteopathic Association has adopted the following “Guide to Section 17 of the AOA Code of Ethics” as follows, and will distribute this information to students of osteopathic medicine and osteopathic physicians (1991, revised 1994, 1999, 2003; 2008; reaffirmed as amended 2015).

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H614-A/15 PHYSICIAN COMPETENCY RETESTING

SUBMITTED BY: Bureau of Osteopathic Specialists

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of Osteopathic Specialists recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H614-A/15 PHYSICIAN COMPETENCY RETESTING
The American Osteopathic Association: (1) supports the mission of physician competency, the quality movement and patient safety through self-regulation mechanisms rather than through government mandated retesting for purposes of obtaining relicensure or for receiving payment under a health benefits program. (2) continue its voluntary efforts to address and promote physician competency through the teaching of core competencies at the predoctoral and postdoctoral levels, physician assessment through osteopathic continuous certification and its AOA Clinical Assessment Program (CAP). 1988; reaffirmed 1993; revised 1998, 2003; revised 2008; revised 2010; reaffirmed as amended 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H615-A/15 HEALTH PLAN COVERAGE OF TOBACCO CESSATION TREATMENT

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H615-A/15 HEALTH PLAN COVERAGE OF TOBACCO CESSATION TREATMENT

The American Osteopathic Association encourages all health plans to follow tobacco cessation recommendations of the Centers for Disease Control and Prevention (CDC) and encourages all health care plans to accept CPT, ICD-9 and ICD-10 codes for tobacco use as legitimate codes for payment for services provided for these codes. 2010; reaffirmed as amended 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H616-A/15 ENCOURAGING PATIENT PARTICIPATION IN THEIR HEALTH CARE

SUBMITTED BY: Bureau of Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H616-A/15 ENCOURAGING PATIENT PARTICIPATION IN THEIR HEALTH CARE

The American Osteopathic Association recommends that all insurance companies consider the establishment of a system for rewarding those patients who are trying to stay healthy as a means of decreasing the amount of money spent on health care. 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN

DATE
SUBJECT: H617-A/15 FRIVOLOUS LIABILITY LAWSUITS

SUBMITTED BY: Bureau of Federal Health Programs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Federal Health Programs recommends that the following policy be SUNSET.

(Old language is crossed out and new language is in CAPS)

H617-A/15 - FRIVOLOUS LIABILITY LAWSUITS
The American Osteopathic Association (AOA) supports, as a component of comprehensive tort reform, the ability of physicians who are victims of frivolous lawsuits to recover all out of pocket expenses and lost income. 2010; reaffirmed as amended 2015

Explanatory Statement: Submitted by Author
A resolution is being submitted that combines this policy with H333-A/18. It will read as follows:

H333-A/18 PROFESSIONAL LIABILITY INSURANCE REFORM
The American Osteopathic Association continues support of professional liability insurance reform that includes the following eight principles: (1) limitations on non-economic damages – including provisions that afford states the opportunity to maintain or establish laws governing limitations on non-economic damages; (2) prohibiting “loss of chance”, (3) periodic payment of future expenses or losses; (4) offsets for collateral sources; (5) joint and several liability reform; (6) limitations on attorney contingency fees; (7) establishment of uniform statutes of limitations; and (8) establishment of alternative professional liability insurance reforms which may include but are not limited to – health courts, non-binding arbitration and I’m sorry clauses; AND (9) REIMBURSEMENT OF ALL OUT-OF-POCKET EXPENSES AND LOST INCOME FOR PHYSICIANS WHO ARE VICTIMS OF FRIVOLOUS LAWSUITS. 1985, revised 1990, 1993, 1998, 2003, revised 2008; reaffirmed 2013, reaffirmed as amended 2018

Background Information: Provided by AOA Staff
Current AOA Policy: H333-A/18 PROFESSIONAL LIABILITY INSURANCE REFORM

Prior HOD action on similar or same topic: Policy reaffirmed as amended in 2018.

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H618-A/15 PROVIDER TAX

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H618-A/15 PROVIDER TAX

The American Osteopathic Association opposes any effort by a state or the federal government to impose a provider tax of any type. 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H619-A/15 MEDICAID PAYMENT

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be REAFFIRM as AMENDED.

(Old language is crossed out and new language is in CAPS)

H619-A/15 MEDICAID PAYMENT

The American Osteopathic Association supports legislation to ESTABLISH MEDICAID-MEDICARE PAYMENT PARITY. 2010; reaffirmed as amended 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H620-A/15 LAY MIDWIVES

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be REAFFIRMED.

3 (Old language is crossed out and new language is in CAPS)

4 H620-A/15 – LAY MIDWIVES
The American Osteopathic Association opposes the licensing of lay midwives and will continue providing support to affiliate societies in opposing state’s efforts to license lay midwives. 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________
DATE ______________________________
RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H621-A/15 MEDICAL MALPRACTICE JUDGMENTS REQUIRING REIMBURSEMENT OF MEDICARE PAYMENTS

The American Osteopathic Association will seek an immediate reversal of the policy of the Centers of Medicare and Medicaid (CMS) requiring a payback of medical care rendered by a provider who has agreed to a malpractice settlement or received a judgment in a malpractice court. 2010; 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H622-A/15 PHYSICIAN ASSISTANCE PROGRAMS FOR TRANSITION TO ELECTRONIC HEALTH RECORDS SUPPORT FOR ADOPTING INNOVATIVE HEALTH INFORMATION TECHNOLOGY

The American Osteopathic Association will continue to work with state osteopathic associations to assist SUPPORT solo practice physicians and small-group practices in the adoption of health information technology (HIT). THE AOA SUPPORTS INCENTIVES OR ENHANCED PAYMENTS FOR ADOPTION OF INNOVATIVE HIT THAT IMPROVES CARE DELIVERY, COORDINATION, AND VALUE. 2005; revised 2010; reaffirmed as amended 2015

Explanatory Statement: Submitted by Author:
This policy was combined with H616-A/19 titled FEDERAL HEALTH INFORMATION TECHNOLOGY INCENTIVES – AOA SUPPORT for broader HIT interoperability. Approval of this resolution would sunset H616-A/19.

Background Information: Provided by AOA Staff
Current AOA Policy: H616-A/19 titled FEDERAL HEALTH INFORMATION TECHNOLOGY INCENTIVES – AOA SUPPORT

Prior HOD action on similar or same topic: Policy reaffirmed in 2019.

FISCAL IMPACT: $0

ACTION TAKEN _______________________
DATE ______________________________
SUBJECT: H624-A/15 PRESCRIPTION MEDICATIONS -- OVERRIDES FOR

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be SUNSET.

(Old language is crossed out and new language is in CAPS)

H624-A/15 PRESCRIPTION MEDICATIONS -- OVERRIDES FOR
The American Osteopathic Association support legislative efforts to: (1) decrease the hold time for physicians and staff for requesting approval from insurance pharmacy plans, (2) require insurance pharmacy plans to allow patients to continue receiving the medications for which they are prescribed and are in good control; and (3) make it easier for a physician to request an approval. 2005; reaffirmed 2010; 2015

Explanatory Statement: Submitted by Author:
Submitted a new resolution for consideration by 2020 HOD titled PRIOR AUTHORIZATION which includes content that covers this topic.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H625-A/15 PEDIATRIC PSYCHIATRIC CARE HEALTH RECORDS

SUBMITTED BY: Bureau of Socioeconomic Affairs / Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs and Bureau on Scientific Affairs and
Public recommends that the following policy be REAFFIRMED.

(Old language is crossed out out and new language is in CAPS)

H625-A/15 PEDIATRIC PSYCHIATRIC CARE HEALTH RECORDS
The American Osteopathic Association supports the development of educational programs to
assist primary care physicians to identify and initiate appropriate support of pediatric psychiatric
care and encourages insurance providers to adequately reimburse counseling and psychiatric
care deemed necessary by the patient’s primary care physician. 2005; reaffirmed 2010; 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H626-A/15 ATTENTION DEFICIT DISORDER / ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD / ADHD)

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H626-A/15 ATTENTION DEFICIT DISORDER / ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD / ADHD)

The American Osteopathic Association urges insurance carriers to provide coverage for attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD) patients by primary care physicians. 2005; reaffirmed 2010; 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE _____________________
SUBJECT: H628-A/15 MEDICARE RECOVERY AUDIT CONTRACTORS

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H628-A/15 MEDICARE RECOVERY AUDIT CONTRACTORS
The American Osteopathic Association will communicate to the Centers for Medicare & Medicaid Services (CMS) its concern about the Medicare Recovery Audit Contractors (RAC) payment methodology. 2005; revised 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _______________________
DATE _____________________________
RESOLVED, that the Bureau on Federal Health Program recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

The American Osteopathic Association recommends that Medicare regulations that restrict a patient's freedom, as well as assess punitive damages to physicians, be challenged and that administrative burdens placed on both the patient and physician be reduced. 1995; revised 2000, 2005; reaffirmed 2010; reaffirmed as amended 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________
DATE ______________________________
SUBJECT: H630-A/15 VETERANS ADMINISTRATION CREDENTIALING OF NON-PHYSICIAN PROVIDERS HEALTH RECORDS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

1 RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED as AMENDED.

3 (Old language is crossed out and new language is in CAPS)

H630-A/15 VETERANS ADMINISTRATION CREDENTIALING OF NON-PHYSICIAN PROVIDERS HEALTH RECORDS

The American Osteopathic Association (AOA) supports the establishment of well-defined credentialing and privileging criteria within the Veterans Administration (VA) that prohibits non-physician providers with expanded scope of practice rights in a minority of states from demanding such privileges in the VA system and supports the establishment of a consistent requirement for the privileging of non-physician providers in the VA system. 2005; reaffirmed 2010; 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE __________________________
RESOLVED, that the Bureau on Federal Health Programs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H631-A/15  TAX CREDITS FOR HEALTH PROFESSION SHORTAGE AREAS

The American Osteopathic Association (AOA) supports the establishment of tax credits for physicians who practice full time in federally designated health professions shortage areas (HPSAs) or Medicare defined physician scarcity areas and federally and/or state designated underserved areas and urges that these tax credits be available, on a sliding scale, to physicians who provide services on a part-time basis in these communities. 2005; reaffirmed 2010; 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0
SUBJECT: H632-A/15  OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) IN A PRE-PAID ENVIRONMENT –PAYMENT POLICIES FOR

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H632-A/15  OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) IN A PRE-PAID ENVIRONMENT –PAYMENT POLICIES FOR

The American Osteopathic Association will work to ensure that: (1) osteopathic manipulative treatment in any prepaid compensation model be recognized as a separate procedure; (2) osteopathic manipulative treatment as a procedure applied by fully-licensed physicians and surgeons be considered unique; and (3) osteopathic manipulative treatment in any prepaid compensation model be compensated as a special separate procedure, either by payment of additional capitation or on a fee-for-service basis without the need for prior authorization. 1995; revised 2000, 2005, 2010; reaffirmed as amended 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H633-A/15 PRESCRIPTION OF DRUGS FOR OFF LABEL USES

SUBMITTED BY: Bureau of Federal Health Programs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Federal Health Programs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H633-A/15 PRESCRIPTION OF DRUGS FOR OFF LABEL USES

The American Osteopathic Association believes it is appropriate for physicians to prescribe approved drugs for uses not included in their official labeling when they can be supported as accepted medical practice. 1995; reaffirmed 2000, 2005, 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE _________________________
SUBJECT: H635-A/15 NEWBORN AND INFANT HEARING SCREENS

SUBMITTED BY: Bureau of Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H635-A/15 NEWBORN AND INFANT HEARING SCREENS

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau of Federal and Health Programs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H636-A/15  MEDICARE PREVENTIVE MEDICAL SCREENING


Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H637-A/15 CONFIDENTIALITY OF PATIENT RECORDS

SUBMITTED BY: Ethics Subcommittee

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Ethics Subcommittee recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H637-A/15 CONFIDENTIALITY OF PATIENT RECORDS

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ___________________________

DATE ________________________________
SUBJECT: H638-A/15 DIABETICS CONFINED TO CORRECTIONAL INSTITUTIONS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED as AMENDED.

(Old language is crossed out and new language is in CAPS)

H638-A/15 DIABETICS PERSONS WITH DIABETES CONFINED TO CORRECTIONAL INSTITUTIONS

The American Osteopathic Association supports the availability of American Diabetes Association (ADA) diabetic meals, beverages, and other diabetic interventions that follow ADA guidelines for all diabetic inmates IMPRISONED PERSONS WITH DIABETES, who are under the care of a licensed physician, and confined in correctional institutions. 2000, revised 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau on Socioeconomic Affairs and Council on AOA Policy recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H639-A/15 DISCRIMINATION BY INSURERS

The American Osteopathic Association will actively pursue all reasonable avenues in support of its members who are discriminated against by insurance companies and excluded from participating in insurance programs; and in those instances where there is no due process to discuss and mediate the exclusions, the AOA will petition organizations to present their credentialing criteria and deselection criteria, and will use those resources at its disposal to help obtain a fair and equitable solution to the problem and to include due process in all cases. 1995; revised 2000, 2005; revised 2010; reaffirmed 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0
RESOLVED, that the Ethics Subcommittee recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

**H640-A/15** EXECUTIONS IN CAPITAL CRIMES CRIMINAL CASES

The American Osteopathic Association deems it an unethical act for any osteopathic physician to deliver or be required to deliver a lethal injection for the purpose of execution in capital crimes. 1995; revised 2000, reaffirmed 2005; 2010; [Editor’s note: In 2015 this policy was referred to the Ethics Subcommittee].

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _______________________

DATE _______________________

**SUBJECT:** H640-A/15 EXECUTIONS IN CAPITAL CRIMES CRIMINAL CASES

**SUBMITTED BY:** Ethics Subcommittee

**REFERRED TO:** Ad Hoc Committee
RESOLVED, that the Bureau of State Government Affairs recommends that the following policy be REAFFIRM as AMENDED.

(Old language is crossed out and new language is in CAPS)

H642-A/15 MANAGED CARE – ALL PRODUCTS CLAUSES
The American Osteopathic Association and state osteopathic societies oppose the use of “all products/all products developed in the future” clauses in physician managed care contracts; actively opposes the use of any other clauses that may limit the ability of the physician to choose the plans in which he or she participates; will educate its members on the potential risks of “all products/all products developed in the future” clauses and the importance of identifying such clauses in contracts prior to their signing; and supports both state and federal legislation as well as regulatory agency regulations and rulings to prohibit the use of “all products/all products developed in the future” clauses in physician managed care contracts. 2000, revised 2005; reaffirmed 2010; 2015.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
SUBJECT: H643-A/15 MEDICAL PROCEDURE PATENTS

SUBMITTED BY: Bureau of Federal Health Program

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Federal Health Program recommends that the following policy be REAFFIRM.

(Old language is crossed out and new language is in CAPS)

H643-A/15 MEDICAL PROCEDURE PATENTS


Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

The American Osteopathic Association calls upon the Centers for Medicare and Medicaid Services (CMS) to continue to involve osteopathic physicians in the development of screening parameters including osteopathic structural diagnoses and manipulative treatments. 1990; revised 1995, 2000, 2005; revised 2010; reaffirmed 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE _____________________
SUBJECT: H646-A/15 OSTEOPATHIC MEDICAL STUDENT, RESIDENT, AND PHYSICIAN MENTAL HEALTH

SUBMITTED BY: Bureau of Emerging Leaders

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Emerging Leaders recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H646-A/15 OSTEOPATHIC MEDICAL STUDENT, RESIDENT, AND PHYSICIAN MENTAL HEALTH

The American Osteopathic Association (AOA) will promote mental health awareness and provide osteopathic medical students, residents, and physicians with educational information on recognizing mental health issues among themselves and their colleagues. The AOA will work with the American Association of Colleges of Osteopathic Medicine, AOA State Divisional Societies, and Advocates for the American Osteopathic Association to reduce the stigma associated with mental illness to eliminate barriers to treatment while advocating for increasing the resources for care. 2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _______________________

DATE _________________________
SUBJECT: H647-A/15 AMERICAN OSTEOPATHIC ASSOCIATION (AOA) OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) COVERAGE DETERMINATION GUIDANCE

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED.

(Old language is crossed out and new language is in CAPS)

H647-A/15 AMERICAN OSTEOPATHIC ASSOCIATION (AOA) OSTEOPATHIC MANIPULATIVE TREATMENT (OMT) COVERAGE DETERMINATION GUIDANCE

The American Osteopathic Association (AOA) approves the attached policy as the standard guidelines for OMT coverage and encourages all public and private payers to refer to the AOA’s policy when developing new policy or revising existing guidance for OMT coverage.

2015

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE _____________________
SUBJECT: ACCESS TO CARE – NETWORK ADEQUACY AND COVERAGE

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, access to health care relies upon both the availability of providers and the patients’ ability to cover the costs of health care services; and

WHEREAS, comprehensive, high-quality health care often involves services from multiple providers across different specialties, often working in collaboration; and

WHEREAS, government regulators and insurance companies have a responsibility to ensure that plan networks have adequate numbers of providers available in-person to provide all necessary services in the beneficiary’s area; now, therefore be it

RESOLVED, American Osteopathic Association (AOA) will advocate to ensure plan coverage by public and private payors for all medically necessary services in-person, within a reasonable distance/wait time for all plan beneficiaries; and be it further

RESOLVED, the AOA support state insurance commissioners as the primary enforcers of network adequacy requirements.

Explanatory Statement: Submitted by Author:

H317-A/15 PATIENT ACCESS IN RURAL AREAS has been reviewed by the Bureau of State Government Affairs and it was determined that the content could be merged into H635-A/16 ACCESS TO CARE – NETWORK ADEQUACY AND COVERAGE to create a more comprehensive, streamlined policy. We suggest that both H317-A/15 and H635-A/16 be deleted and replaced with this resolution. Relevant revised language from those resolutions has been included in this resolution:

H317-A/15 PATIENT ACCESS IN RURAL AREAS
The American Osteopathic Association supports policy on the state and federal levels that would require all managed care health plans to have reasonably placed network physicians and hospital access; if the distance is unreasonable, the plans should pay for out of network services at no additional cost to the patient.

H635-A/16 ACCESS TO CARE – NETWORK ADEQUACY AND COVERAGE
The American Osteopathic Association (AOA) will advocate for public and private payors TO ensure plan coverage BY PUBLIC AND PRIVATE PAYORS for all medically necessary services IN-PERSON, WITHIN A REASONABLE DISTANCE/WAIT TIME FOR ALL PLAN beneficiaries, and supporting state regulators INSURANCE COMMISSIONERS as the primary enforcers of network adequacy requirements.
Background Information: Provided by AOA Staff

Current AOA Policy:
H309-A/16 PATIENT ACCESS IN RURAL AREAS
H635-A/16 ACCESS TO CARE – NETWORK ADEQUACY AND COVERAGE

Prior HOD action on similar or same topic: H309-A/16 policy reaffirmed in 2016; H635-A/16 policy approved in 2016.

FISCAL IMPACT: $0

ACTION TAKEN _______________________

DATE _________________________
SUBJECT: ADDRESSING FEARS AND BARRIERS TO TELEMEDICINE IMPLEMENTATION AND ALIGNMENT

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Ad Hoc Committee

WHEREAS, telemedicine is becoming a growing entity and option for healthcare services; and

WHEREAS, the potential convenience and lower costs of telemedicine may be highly attractive to patients; and

WHEREAS, many physicians have expressed concern that telemedicine could adversely affect the patient/physician relationship, quality of care, and/or patient safety; and

WHEREAS, appropriate oversight and regulations for telemedicine services are lacking; and

WHEREAS, inferior technology and network coverage can affect consistent services; and

WHEREAS, empowering a physician’s ability to engage and implement telemedicine could increase revenue, practice marketing options, and enhance relationships with physician’s existing patients; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) engage partner organizations to support understanding, training and implementation of telemedicine in physician offices; and, be it further

RESOLVED, that the AOA engage in evaluating processes that help our physicians implement telemedicine in practices.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff

Current AOA Policy: H601-A/17 TELEMEDICINE – AOA POLICY ON

Prior HOD action on similar or same topic: Policy approved as amended in 2017.

FISCAL IMPACT: $0

Finance Committee Explanatory Statement – The general provisions included in this resolution may be incorporated into the AOA’s existing processes without additional fiscal impact. Activities undertaken through the educational, legislative and legal realms currently address evolving telemedicine issues as warranted. Additional efforts would require shifting of resources, but without an expectation of additional expenditures at this time.

ACTION TAKEN ______________________

DATE ______________________________
WHEREAS, equity in health and overall wellbeing is not simply determined by individual choices but based on life chances and the resources provided in the environment one is born into\(^1\); and

WHEREAS, consistent structural differences in social opportunities amongst the indigent compared to the affluent is as important to life expectancy and health outcomes as affordable access to medical treatment\(^1\); and

WHEREAS, the glaring inequality in freedom to live a thriving, healthy life can be balanced through concerted effort to reverse structural drivers including policies, economics, and living conditions to ensure a sustainable standard of health across all socioeconomic and cultural backgrounds\(^1\); and

WHEREAS, there is widespread support for screening tools to measure social determinants of health (SDoH) such as food insecurity, domestic violence, and housing quality that currently exist in clinical practice\(^1\); and

WHEREAS, implementation of comprehensive screening with adequate linked cooperation to local community resources was a noted barrier to practical use\(^3\); and

WHEREAS, the success of promising universal assessment tools, such as the Center for Medicare and Medicaid Services’ Accountable Health Communities (AHC) Model, could be limited by inadequate funding, lack of hospital cooperation, and omission of essential social and behavioral measures\(^4\); and

WHEREAS, American Osteopathic Association (AOA) aims to promote public health and accentuate the distinctive philosophy of Osteopathic Medicine to treat the whole-person as affirmed by AOA Policy H406-A/17 and H300-A/18; and

WHEREAS, private sector organizations are working with national medical organizations through the Integrated Health Model Initiative (IHMI) to address the issue of SDoH systematically through the process of creating relevant ICD-10 codes related to “critical factors of patient well-being, such as employment, education, food, housing, access to transportation, and many other factors” which will trigger social services referrals\(^5\); and

WHEREAS, ICD-10-CM is an international classification of diseases that plays a fundamental role in health care delivery and payment policy, and it has recently been adapted in the United States to include clinical modification (CM) which expands implications to precise measuring, disease tracking, health care utilization, and quality of patient care.
including codes “Z00-Z99” for factors influencing health status and contact with health services; and

WHEREAS, projects exist that aim to improve screening, diagnosis, treatment, and planning by using technology to streamline data collection by defining a coded library of terms related to SDoH and use interoperability of electronic health systems to address individual patient needs more effectively; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) will adopt an official position that supports the use of ICD-10-CM codes regarding social determinants of health that mitigate challenges of physician referrals to social or government resources; and, be it further

RESOLVED, that the AOA support legislation that improves interoperability of electronic health records to reduce overall health care costs by improving communication between members of a care team, including social services; and, be it further

RESOLVED, that the AOA support a validated screening tool to identify patients influenced by social determinants of health.

Explanatory Statement: Submitted by Author:
Please note the use of “structural drivers” in line 7 refers to gender norms and values, economic participation, social exclusion, wealth distribution, education, civil rights, governance, public spending priorities, and macroeconomic conditions. Further, note that the phrase “validated screening tool” referenced in line 51 indicates issuing a position of support for the creation of a standardized measurement of social determinants of health in individual patients that can be used across the nation, in any setting, and that has been authenticated to accurately assess patients at risk without any bias or skew towards certain demographics. This tool is indicated to be used at patient intake to identify individuals, such that the proper ICD-10 codes can be documented at the time of the encounter. Please be advised that the use of the term “support(s)” in the resolved statements is meant to indicate that SOMA and the AOA will use their judgement to promote the utilization of existing ICD-10 codes whether it be issuing a statement of support, lobbying for federal legislation relating to these codes, etc.

References


Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN ________________________________________

DATE ________________________________________
SUBJECT: ELIMINATION OF PRIOR AUTHORIZATION AND STEP THERAPY

SUBMITTED BY: Michigan Osteopathic Association

REFERRED TO: Ad Hoc Committee

WHEREAS, US healthcare spending is significantly greater for administrative costs than other countries; and

WHEREAS, substantial costs to medical practices are required in order to process Prior Authorizations (PAs); and

WHEREAS, administrative burdens to healthcare providers concerning PAs have substantially increased thus leading to higher cost and delays to patient care and the related adverse outcomes resulting from delays or denials of patient care; and

WHEREAS, legislative attempts to address PA issues have focused on transparency, rather than addressing the barriers to timely patient care; and

WHEREAS, PA burdens in medical practice have increased significantly; and

WHEREAS, PA’s and step therapy have been shown to lead to unnecessary hospitalizations and overall health care, cost as well as increased patient morbidity and mortality; now, therefore be it

RESOLVED, that the American Osteopathic Association advocate for elimination of prior authorizations as a third payor pre-requisite for the provision of quality health care in order to avoid harm and/or death due to delays in care.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff

Current AOA Policy:
H343-A/13 CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE FOR PRIOR AUTHORIZATION
H602-A/15 REIMBURSEMENT FOR PHYSICIAN TIME SPENT OBTAINING PRE-CERTIFICATION AND PRE-AUTHORIZATION
H640-A/16 PRIOR AUTHORIZATION
H632-A/17 PRIOR AUTHORIZATION
H635-A/19 PRIOR AUTHORIZATION - PATIENT AUTHORIZATION

Prior HOD action on similar or same topic: H343-A/13 policy reaffirmed in 2013 (referred to BSA in 2018); H602-A/15 policy approved in 2015; H640-A/16 policy approved in 2016; H632-A/17 policy approved in 2017, H635-A/19 policy approved in 2019
FISCAL IMPACT: $0

ACTION TAKEN _____________________
DATE ______________________________
RES. NO. H640 - October 13, 2020 – Page 1

SUBJECT: H623-A/18 NON-PHYSICIAN CLINICIANS

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, the Bureau of State Government Affairs (BSGA) convened a workgroup to review the American Osteopathic Association’s (AOA) Non-Physician Clinicians policy in light of the ongoing attempts by non-physician clinicians to independently practice medicine, despite wide variances in their education, training, and competency demonstration requirements (all of which fall short of the nationally standardized requirements for physicians); and,

WHEREAS, current AOA policy H623-A/18 NON-PHYSICIAN CLINICIANS supports either (undefined) “collaboration” or “supervision” by physicians, to ensure meaningful physician involvement and oversight in states that do not currently allow non-physician clinicians to practice independently; and

WHEREAS, it is the belief of the BSGA that the AOA should retain its current opposition to independent practice for non-docs, and add support for regulating these professionals by state medical licensing boards in states that currently allow non-physician clinicians to practice independently by law, to ensure that they are being held to the same standards of care as physicians; now, therefore be it

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED AS AMENDED.

H623-A/18 NON-PHYSICIAN CLINICIANS The American Osteopathic Association has adopted the attached policy paper as its position on non-physician clinicians including appropriate onsite supervision. 2000, revised 2005; revised 2010; reaffirmed 2015; revised 2018

Policy Statement - 2018 NON-PHYSICIAN CLINICIANS

OVER THE COURSE OF THE PAST CENTURY, SCIENTIFIC AND TECHNOLOGICAL ADVANCEMENTS HAVE LED TO IMPROVEMENTS IN THE TREATMENT OF DISEASE AND STANDARDS OF PATIENT CARE. AS A RESULT, THE STANDARDIZED MEDICAL EDUCATION, SUPERVISED POSTGRADUATE (“RESIDENCY”) TRAINING AND EXAMINATION SERIES THAT THE DO/MD PHYSICIANS IN THE UNITED STATES ARE REQUIRED TO COMPLETE IN ORDER TO OBTAIN AN UNLIMITED MEDICAL LICENSE HAS INCREASED AS WELL. AT THE SAME TIME, HOWEVER, SOME STATES ARE CREATING LEGISLATIVE PATHWAYS TO INDEPENDENT MEDICAL PRACTICE FOR OTHER TYPES OF CLINICIANS, DESPITE THE ABSENCE OF NATIONALLY STANDARDIZED EDUCATION, TRAINING AND TESTING PATHWAYS FOR THESE CLINICIAN GROUPS, OR EVIDENCE REGARDING PATIENT SAFETY OUTCOMES.
The current DO/MD medical model, in which medical students and resident physicians are required to demonstrate their ability to safely provide care to patients under the supervision of fully licensed physicians, leading to greater autonomy over time, has proven its ability to provide professionals with the complete knowledge and skill base needed to ensure patient safety and optimize outcomes. In addition, most states impose additional continuing medical education (CME) requirements, and many physicians elect to undergo rigorous certifying board examinations to demonstrate excellence in a particular specialty, which helps to ensure that physicians remain trained to provide the current highest standard of patient care over the course of their careers.

Thus, it is appropriate that the practice of medicine and the quality of medical care remain the responsibility of properly licensed physicians, who are the only clinician group properly trained, licensed and regulated according to uniform laws governing medical licensure in the United States. The American Osteopathic Association (AOA) further values the unique training and contributions of all members of the patient care team, and supports the concept of uniform licensure pathways for non-physician clinician groups, based upon scope of practice. The AOA further supports appropriate physician involvement in patient care provided by non-physician clinicians, and opposes any legislation or regulations which would authorize the independent practice of medicine by an individual who has not completed the state's requirements for physician licensure.

As non-physician clinicians continue to seek wider roles, public policy dictates that patient safety and proper patient care should be foremost in mind when the issues encompassing expanded practice rights for non-physician clinicians—autonomy, scopes of practice, prescriptive rights, liability and reimbursement, among others—are addressed.

A. Patient Safety. The AOA supports the “team” approach to medical care, with the physician as the leader of that team. The AOA further supports the position that patients should be made clearly aware at all times whether they are being treated by a non-physician clinician or a physician. The AOA recognizes the growth of non-physician clinicians and supports their rights to practice with appropriate physician involvement within the scope of the relevant state statutes.

B. Independent Practice. It is the AOA’s position that roles within the “team” framework must be clearly defined, through established state-level supervisory protocols and signed agreements, so physician involvement in patient care is sought when a patient’s case dictates and patients can rest assured that physician involvement in their care will remain the same regardless of practice setting within the state. The AOA feels nonphysician clinician professions that have traditionally been under the supervision of physicians must retain physician involvement in patient care. Those non-physician clinician professions that have traditionally remained independent of physicians must involve
physicians in patient care when warranted. FURTHER, All non-physician clinicians must refer a patient to a physician when the patient’s condition is beyond the non-physician clinician’s scope of education, training or expertise.

C. Liability. The AOA endorses the view that physician liability for non-physician clinician actions should be reflective of the quality AND DEGREE of supervision being provided and should not exonerate the non-physician clinician from liability. It is the AOA’s position that non-physician clinicians acting PROVIDING CARE IN INDEPENDENT PRACTICE STATES autonomously of physicians should be REGULATED AND DISCIPLINED BY THE ENTITIES RESPONSIBLE FOR REGULATING AND DISCIPLINING PHYSICIANS (I.E. STATE MEDICAL BOARDS), TO ENSURE THAT ALL CLINICIANS WHO ARE INDEPENDENTLY PRACTICING MEDICINE ARE held to the SAME STANDARD OF CARE AND THE equivalent degree of liability as that of a physician. Within this independent practice framework, TO THAT END, the AOA further believes that non-physician clinicians should be required to obtain EQUIVALENT malpractice insurance in those states that currently require TO physicians IN STATES THAT CURRENTLY REQUIRE PHYSICIANS to possess malpractice insurance.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: H623-A/18 NON-PHYSICIAN CLINICIANS

Prior HOD action on similar or same topic: Policy approved as amended in 2018.

Fiscal Impact: $0

ACTION TAKEN ______________________

DATE ___________________________
WHEREAS, the American Osteopathic Association (AOA) has deeming authority from the U.S. Department of Education to certify physicians; and

WHEREAS, AOA board certified physicians have historically been supportive and involved members of the AOA and its divisional societies; and

WHEREAS, the AOA, and its state associations’ and specialty colleges’, collectively known as divisional societies, health and viability will be strengthened by having many early career physicians sit for AOA examinations; and

WHEREAS, graduates of Accreditation Council of Graduate Medical Education (ACGME) programs must be informed of and provided reasons for pursuing AOA board certification; and

WHEREAS, the eighteen (18) AOA certifying boards depend upon item-writers who are overwhelmingly practicing physicians; and

WHEREAS, the AOA internally uses the tag line “Practicing Physicians Certifying Practicing Physicians”; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) implement a branding campaign for its specialty certifying boards to include incorporating the tag line “Practicing Physicians Certifying Practicing Physicians” on all AOA certifying boards webpages and letterhead; and, be it further

RESOLVED, that the AOA develop and broadly distribute a one-page info sheet targeting Graduate Medical Education (GME) sponsoring institutions, program directors, postdoctoral trainees, and board-eligible physicians; and, be it further

RESOLVED that the info sheet shall incorporate the tag line “Practicing Physicians Certifying Practicing Physicians” and discuss AOA certification in terms of relevance of exam to practice, affordability, value, convenience and ease of maintenance.

Explanatory Statement: Submitted by Author:
Potential candidates must be provided with reasons for pursuing AOA Board Certification: distinctiveness, value, relevance of exam to practice, affordability, convenience and ease of maintenance.

With ease of electronic communication and website branding, this resolution can be implemented with low costs and may help to expand our customer base and thus drive revenues to the certifying boards, specialty colleges, and the AOA.
The following Divisional Societies have endorsed this resolution:

- American Academy of Osteopathy
- American College of Osteopathic Family Physicians
- American College of Osteopathic Internists
- American College of Osteopathic Obstetricians & Gynecologists
- American College of Osteopathic Pediatricians
- American Osteopathic Academy of Addiction Medicine
- American Osteopathic Academy of Orthopedics
- American Osteopathic Academy of Sports Medicine
- American Osteopathic College of Dermatology
- American Osteopathic College of Occupational and Preventive Medicine
- American Osteopathic Colleges of Ophthalmology and Otolaryngology – Head and Neck Surgery
- American Osteopathic College of Pathologists

Background Information: Provided by AOA Staff

Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: Up to $59,500 in additional expense.

The additional expenses incurred if the AOA pursued this resolution would consist of the cost of disposing current letterhead and business cards and the estimated costs of reprinting letterhead and business cards of $10,500, and estimated costs for rebranding between $16,500 and $49,000 at $165 per hour. Rebranding could be from 100 to 300 hours including 30-40 hours for content and design work by AOA staff. The range of additional expenses would be between $27,000 and $59,500.

ACTION TAKEN _____________________

DATE _____________________________
SUBJECT: PRIOR AUTHORIZATION

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, prior authorization (PA) results in care delays and adverse events, with a recent American Medical Association survey finding that 91% of physicians report care delays associated with PA and 28% report that PA has led to serious adverse events for their patients; and

WHEREAS, prior authorization increases administrative burden for physicians with 86% of physicians citing high level of burden associated with PA requirements; and

WHEREAS, the American Osteopathic Association has numerous policies relating to PA and the 2019 House of Delegates directed the Bureau of Socioeconomic Affairs to unify policies into a comprehensive policy statement; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) adopts the following policy and principles statement on prior authorization; and be it further

RESOLVED, the AOA will merge policies H343-A/13, H602-A/15; H632-A/17, H635-A/19, H637-A/19, and H640-A/16.

Prior Authorization

Prior authorization requirements have been found to result in care delays that place patients at risk and to increase provider burden. In order to ensure that prior authorization is implemented in an appropriate manner that minimizes burden and risk, the AOA believes that implementation of PA by payers and pharmacy benefit managers should abide by the following principles.

- Prior authorizations should be clinically relevant, evidence-based, transparent, and as minimally intrusive on the physician, medical staff, and patient as possible.
- Prior authorization programs that negatively impact access to care, delay treatment, result in abandonment, increase cost of care and administrative costs, do not align with recognized clinical practice guidelines, or have a negative impact on quality of care or outcomes should be discontinued.
- Payors should appropriately compensate providers for complying with utilization review.
- Prior authorization request forms should be standardized and electronic whenever feasible to promote procedural uniformity and reduce administrative burden.
- Allow continuation of medications already being administered or prescribed when a patient changes health plans and not allow changes without discussion and approval of the ordering physician.

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• Providers should be notified of changes to prior authorization requirements at least 45 days prior to change.

• Payors and Plans should be required to report a list of services and prescription medications subject to prior authorization and corresponding denial, delay, and approval rates.

• Prior authorization requirements should be minimized as much as possible and eliminate the application of prior authorization to services and prescription medications that are routinely approved.

• There should be an easily accessible and responsive direct communication tool to resolve conflicts between health plans and ordering physicians.

As part of its efforts to advocate for these principles and ensure their incorporation into policy, the AOA will advocate for legislation and regulatory changes that would require payers and pharmacy benefit managers to:

• Disclose in sales, promotional materials and advertising that their products utilize a prior authorization process which may result in a delay in or denial of diagnosis and or treatment which may be detrimental to the patient's health or well-being.

• Consider a physician’s attestation of clinical diagnosis or order sufficient documentation of medical necessity for durable medical equipment.

• Include in contracts with healthcare providers hold harmless clauses that indemnify healthcare providers against financial loss due to injury to a patient as a result of the payor’s failure or refusal to grant a prior authorization request in a timely manner.

• Provide appropriate notice to patients and physicians when formulary and benefit changes are made.

• Include a correct phone number and web address on the patient identification card for initiating the prior authorization process; Make all forms used in the prior authorization process readily available to healthcare providers, including EMR templates.

• Publish and make available to the public all requirements for prior authorization and follow those published policies.

• Provide sufficient knowledgeable staff to ensure that healthcare providers are able to contact medical claims payers and pharmacy benefit managers without average hold times exceeding 10 minutes.

• Compensate medical practices and healthcare providers for the cost of time spent on inappropriately denied PA requests; and

• To identify and hold accountable the payor’s medical director/claim adjudicator for the results of their decisions.

Explanatory Statement: Submitted by Author
Upon approval of this resolution the policies noted in the last resolved statement will be sunset.

Background Information: Provided by AOA Staff
Current AOA Policy:
H343-A/13 CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE FOR PRIOR AUTHORIZATION
H602-A/15 REIMBURSEMENT FOR PHYSICIAN TIME SPENT OBTAINING PRE-CERTIFICATION AND PRE-AUTHORIZATION
H640-A/16 PRIOR AUTHORIZATION
H632-A/17 PRIOR AUTHORIZATION
H635-A/19 PRIOR AUTHORIZATION – PATIENT AUTHORIZATION

Prior HOD action on similar or same topic: H343-A/13 policy reaffirmed in 2013 (referred to BSA in 2018); H602-A/15 policy approved in 2015; H640-A/16 policy approved in 2016; H632-A/17 policy approved in 2017, H635-A/19 policy approved in 2019

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ________________________
WHEREAS, the current state of the legal system imposes great costs on the U.S. health care system and society in general by forcing physicians to maintain costly amounts of professional liability insurance; and

WHEREAS, these costs may ultimately be borne by patients through increased prices or through the loss of solo/small group practices in rural and underserved areas, where physicians may be unable to afford the cost of this insurance; and

WHEREAS, this legal system incentivizes physicians to practice defensive medicine to protect themselves from litigation, and discourages some physicians from pursuing riskier specialties such as obstetrics, even though specialists in these areas are needed; now, therefore be it

RESOLVED, that the American Osteopathic Association continues support of professional liability insurance reform that includes the following principles:

1) limitations on non-economic damages - including provisions that afford states the opportunity to maintain or establish laws governing limitations on non-economic damages;
2) prohibiting “loss of chance” liability;
3) periodic payment of future expenses or losses;
4) offsets for collateral sources;
5) joint and several liability reform;
6) limitations on attorney contingency fees;
7) establishment of uniform statutes of limitations;
8) establishment of alternative professional liability insurance reforms which may include but are not limited to – health courts, non-binding arbitration and I’m sorry clauses; and
9) reimbursement of all out-of-pocket expenses and lost income for physicians who are victims of frivolous lawsuits.

and, be it further

RESOLVED, that upon approval, AOA policies H617-A/15 FRIVOLOUS LIABILITY LAWSUITS and H333-A/18 PROFESSIONAL LIABILITY INSURANCE REFORM be sunset.

Explanatory Statement: Submitted by Author

H617-A/15 FRIVOLOUS LIABILITY LAWSUITS has been reviewed by the Bureau of State Government Affairs and it was determined that the content should be merged into H333-A/18 PROFESSIONAL LIABILITY INSURANCE REFORM to create a more comprehensive, streamlined
policy. We suggest that both H617-A/15 and H333-A/18 be deleted and replaced with this resolution. Relevant revised language from those resolutions has been included in this resolution:

**H617-A/15 FRIVOLOUS LIABILITY LAWSUITS**
The American Osteopathic Association (AOA) supports, as a component of comprehensive tort reform, the ability of physicians who are victims of frivolous lawsuits to recover all out of pocket expenses and lost income.

**H333-A/18 PROFESSIONAL LIABILITY INSURANCE REFORM**
The American Osteopathic Association continues support of professional liability insurance reform that includes the following eight principles: (1) limitations on non-economic damages – including provisions that afford states the opportunity to maintain or establish laws governing limitations on non-economic damages; (2) prohibiting “loss of chance”, (3) periodic payment of future expenses or losses; (4) offsets for collateral sources; (5) joint and several liability reform; (6) limitations on attorney contingency fees; (7) establishment of uniform statutes of limitations; and (8) establishment of alternative professional liability insurance reforms which may include but are not limited to – health courts, non-binding arbitration and I’m sorry clauses; **AND (9) REIMBURSEMENT OF ALL OUT-OF-POCKET EXPENSES AND LOST INCOME FOR PHYSICIANS WHO ARE VICTIMS OF FRIVOLOUS LAWSUITS.**

Background Information: Provided by AOA Staff

**Current AOA Policy:**
H617-A/15 FRIVOLOUS LIABILITY LAWSUITS
H333-A/18 PROFESSIONAL LIABILITY INSURANCE REFORM

**Prior HOD action on similar or same topic:** H617-A/15 policy approved in 2015; H333-A/18 policy approved in 2018.

**FISCAL IMPACT:** $0

ACTION TAKEN _______________________

DATE _____________________________
SUBJECT: RE-ESTABLISHMENT OF THE BUREAU OF OSTEOPATHIC SPECIALTY SOCIETIES (BOSS)

SUBMITTED BY: American Osteopathic College of Occupational and Preventive Medicine

REFERRED TO: Ad Hoc Committee

WHEREAS, the American Osteopathic Association’s (AOA) Bureau of Osteopathic Specialty Societies (BOSS), existed to allow for elected representatives from each of the specialty colleges to assemble to discuss AOA policy proposals and their impact on the Specialty Colleges; and

WHEREAS, other AOA Bureaus, Councils and Committees were able to refer matters to the BOSS for comment and refinement; and

WHEREAS, the BOSS was discontinued without provision of an alternative structure to ensure that specialty college elected leaders continued to have a vehicle for collaborative discernment on matters affecting their members; and

WHEREAS, the AOA Council on Osteopathic Continuing Medical Education (COCME), recently asked the Bureau of Osteopathic Specialists (BOS), the Bureau representing the AOA’s Specialty Certifying Boards, to weigh in on proposed changes to CME requirements, including the tracking of specialty credits; however, the specialty colleges had no venue or opportunity to provide input; and

WHEREAS, sweeping changes to CME requirements and the tracking of specialty credits impact CME attendance at specialty college events and have significant fiscal impact on divisional societies, organized elements within the AOA structure should exist to solicit debate and support among key constituent groups, including the specialty college elected leaders; and

WHEREAS, since the disbandment of BOSS, the profession has gained additional expertise, experience and competence meeting in a virtual environment, the BOSS can now be re-implemented with very little fiscal impact to the AOA; now, therefore be it

RESOLVED, that the Bureau of Osteopathic Specialty Societies (BOSS) be re-established, whose membership is comprised of one elected representative from each specialty society; and, be it further

RESOLVED, that the American Osteopathic Association (AOA) host at least two meetings per year: one prior to the AOA Mid-Year Board of Trustees meeting and the other prior to the Annual Business Meeting; as well as other times as requested by the BOSS; and, be it further

RESOLVED that the AOA can organize these meetings in a virtual or hybrid environment, in conjunction with the AOA Mid-Year Board of Trustees meeting and the Annual Business Meeting, to minimize the fiscal impact to the AOA and the specialty colleges.
Explanatory Statement: Submitted by Author
The Bureau of Osteopathic Specialty Societies (BOSS) enable elected leaders of the specialty colleges to come together to discuss a myriad of issues:

- Proposed AOA Board and House resolutions
- Joint responses to public comment periods from other AOA Bureaus, Councils and Committees
- Joint responses to public comment periods from the ACGME, COCA, and various federal government agencies (HRSA, MEDPAC, CMS, etc.)
- Advocacy for needed revisions to ACGME Common Program requirements
- Collaboration on common issues, such as student chapters, supporting of transitions from medical school to postdoctoral training
- Tracking of and service to postdoctoral trainees
- Joint CME programming and planning

The following divisional societies have endorsed this resolution:

- American Academy of Osteopathy
- American College of Osteopathic Family Physicians
- American College of Osteopathic Emergency Physicians
- American College of Osteopathic Obstetricians & Gynecologists
- American College of Osteopathic Pediatricians
- American College of Osteopathic Surgeons
- American Osteopathic Academy of Addiction Medicine
- American Osteopathic Academy of Sports Medicine
- American Osteopathic Association of Prolotherapy Regenerative Medicine
- American Osteopathic College of Anesthesiologists
- American Osteopathic College of Dermatology
- American Osteopathic College of Occupational and Preventive Medicine
- American Osteopathic Colleges of Ophthalmology and Otolaryngology – Head and Neck Surgery
- American Osteopathic College of Pathologists

Background Information: Provided by AOA Staff
Current AOA Policy: None

Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________
DATE ______________________________
SUBJECT: REFERRED RESOLUTION: H636-A/2019 OBESITY TREATMENT REIMBURSEMENT IN PRIMARY CARE

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, the AOA House of Delegates (HOD) referred resolution H-636-A/2019 titled OBESITY TREATMENT REIMBURSEMENT IN PRIMARY CARE submitted by the Michigan Osteopathic Association; and

WHEREAS, the HOD requested the Bureau of Socioeconomic Affairs “review the feasibility of obtaining payment for the treatment of obesity as a primary diagnosis and whether new CPT and diagnosis codes need to be created for payment purposes”; now, therefore be it

RESOLVED, that resolution H-636-A/2019 titled OBESITY TREATMENT REIMBURSEMENT IN PRIMARY CARE, be ADOPTED as amended

RES. NO. H-636 - A/2019

SUBJECT: OBESITY TREATMENT REIMBURSEMENT IN PRIMARY CARE

WHEREAS, the prevalence of obesity was 39.8% and affected about 93.3 million of US adults in 2015~2016; and

WHEREAS, Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer that are some of the leading causes of preventable, premature death; and

WHEREAS, ensuring physician reimbursement for obesity treatment should be a priority to reduce morbidity and mortality of the population; and

WHEREAS, it is well within the scope of practice of ALL primary care physicians to treat this condition and obesity is not currently a payable diagnosis for primary care; now, therefore, be it

RESOLVED, that the American Osteopathic Association (AOA) publicly affirms and advocates that all diagnosis codes for obesity and morbid obesity be a billable and reimbursable diagnostic code for any and all practicing primary care physicians IS COMMITTED TO EXPANDING PAYMENT FOR SERVICES RELATED TO OBESITY DIAGNOSIS AND TREATMENT, INCLUDING NON-PRIMARY CARE PHYSICIANS AND NON-PHYSICIANS WHO PROVIDE COUNSELING IN CONSULTATION WITH A PHYSICIAN; and, be it further
RESOLVED, that the AOA WILL work with insurers, payors, legislators, and other stakeholders to ensure access to treatment for obesity to address this public health epidemic.

References

Explanatory Statement: Submitted by Author:
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN __________________________

DATE __________________________
SUBJECT: POST PARTUM DEPRESSION (Response to RES. NO. H-612 - A/18 referencing H-615-A/13)

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Ad Hoc Committee

WHEREAS, on July 21, 2018, the House of Delegates (HOD) Ad Hoc Reference Committee referred H615-A/13 POSTPARTUM DEPRESSION to the Bureau on Scientific Affairs and Public Health (BSAPH) to produce a report on outcomes; and

WHEREAS, at the 2019 HOD the BSAPH requested and received additional time to collect the requested data from AOA’s internal sources as well external key stakeholders (e.g., COMS, osteopathic state, and specialty associates); and

WHEREAS, the BSAPH developed and administered a survey to its external stakeholders to collect the requested information and provide a final report to the HOD in 2020; now,

therefore be it,

RESOLVED, that the Bureau of Scientific Affairs and Public Health recommends that the following policy be REAFFIRMED.

H615-A/13 POSTPARTUM DEPRESSION

The American Osteopathic Association encourages its members to participate in continuing medical education programs on postpartum depression (PPD); urges colleges of osteopathic medicine (COMs) and osteopathic state and specialty associations to offer CME on PPD as part of their educational offerings; and endorses the use of screening tools and encourage the measurement of outcomes in their use. 2003; 2008; reaffirmed as amended 2013.

Explanatory Statement: Submitted by Author

Introduction

Postpartum depression is a type of depression that occurs after women give birth. Symptoms of postpartum depression are more severe and enduring than those of “baby blues,” which describes the worry, sadness, and tiredness many women combat after having a baby. Postpartum depressive symptoms (PDS) are common, and they can impact the mother, infant and family. PDS have been linked to adverse maternal and infant outcomes, including low breastfeeding initiation and duration and poor maternal and infant bonding. (Ko JY, 2017)

Fathers may also experience depression during the first year of their child’s life. According to the Centers for Disease Control and Prevention (CDC), about 1 out of 5 fathers will suffer one or more incidences of depression before their child reaches 12 years of age. Younger fathers, those with a history of depression, and those experiencing financial challenges were most susceptible. (Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, 2020)

Based on the Pregnancy Risk Assessment Monitoring System (PRAMS) data, the CDC estimates that 1 in 8 women nationally experience PDS. (America's Health Rankings, 2019). Estimates of the number of
women affected by postpartum depression vary by age and race/ethnicity. Additionally, postpartum depression estimates differ by state, and can be as high as 1 in 5 women (Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, 2020).

Postpartum depression may be prevented and/ or mitigated by ensuring women have supportive and psychological care following childbirth. This includes home visits, peer support and interpersonal therapy. (Donna E. Stewart, 2016) Additionally, Postpartum Depression (PPD) is treatable with social support, counseling, and/ or medication. Though most people recover with treatment of PPD, many are not screened or diagnosed (America's Health Rankings, 2019).

Studies indicate that 66 percent of past-year depression among pregnant women in the US were undiagnosed, and only half of pregnant women with depressive symptoms received treatment. Studies also uncovered several barriers to treatment among women with PPD, particularly among Latinx and African American women. Given the significant burden of PPD, and the fact that PPD is preventable and highly treatable, the US public health strategy, Healthy People 2020, includes an objective to reduce the number of women who experience postpartum depressive symptoms subsequent to a live birth. (America's Health Rankings, 2019)

Osteopathic CME Education on PPD
In 2020, the BSAPH distributed a survey to 150 osteopathic CME providers at colleges of osteopathic medicine (COMs) and osteopathic state and specialty associations to ascertain whether or not the affiliate groups offered continuing medical education programs on PPD, endorsed the use of screening tools, or encouraged outcomes measurement from 2014 through 2019.

Sixty-nine (46%) organizations responded to the survey. Nine respondents (13%) reported a total of 26 educational CME activities on PPD delivered to their constituents from 2014 through 2019. The majority of the activities were live events, and as many as 1200 learners participated. Three (4%) of the organizations also promoted screening tools and encouraged outcomes measurement.

Conclusions/ Recommendations
There has been some education in the osteopathic community on PPD. However, depression for many women across the country is still a very significant issue that is underdiagnosed and untreated. Therefore, it is recommended that the AOA continue to encourage the osteopathic community to provide and participate in continuing medical education on PPD and the best practices for screening, diagnosis, monitoring and treatment.

References

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None
**FISCAL IMPACT:** Up to approximately $130,000 in additional expense. The amount of additional expense will depend upon the type of activity and number of CME hours involved. For example, a conservative estimate based upon a one CME hour journal article would be $13,000, whereas, a high-end estimate based upon a 10 credit CME in-person workshop could be $130,000.

**ACTION TAKEN** __________________________

**DATE** __________________________

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

WHEREAS, the AOA House of Delegates referred sunset resolution H-619-A/2019 titled H624-A/14 MANAGED CARE PLANS – SERVICE, ACCESS AND COSTS IN to the Bureau of Socioeconomic Affairs for “clarification on intent of the resolution, definition of “open access models”, and relevance of the resolution”; now, therefore be it

RESOLVED, that the Bureau of Socioeconomic Affairs recommends that the following policy be REAFFIRMED as AMENDED:

H624-A/14 MANAGED CARE PLANS – SERVICE, ACCESS AND COSTS IN

The American Osteopathic Association (AOA) supports efforts to combine tiered formulary and open access models with expanded THE use of variable co-pays that reflect the total THAT SUPPORT PROGRAM costs, of these programs and THE AOA ALSO supports efforts to design benefits that align consumer needs, and accountability and individual physician incentives. 1999; revised 2004; reaffirmed as amended 2009; reaffirmed as amended 2014

Explanatory Statement: Submitted by Author:
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy: None
Prior HOD action on similar or same topic: None

FISCAL IMPACT: $0

ACTION TAKEN _____________________

DATE ______________________________
WHEREAS, mid-level practitioners, defined as, but not limited to, health-care providers such
as nurse practitioners, nurse midwives, nurse anesthetists, clinical nurse specialists and
physician assistants have increasingly sought expanded scope of practice with success;
and

WHEREAS, nurse practitioners (NPs) now have full scope of practice in 24 states with
intention to continue expansion of scope efforts; and

WHEREAS, NPs have introduced a new degree, DNP, or Doctor of Nursing Practice, that has
increased confusion for patients in clinical settings, where said DNPs refer to
themselves as doctors, and at times do not adequately inform patients that they are not
physicians; and

WHEREAS, The Code of Federal Regulations defines the term physician to include doctors of
medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists,
chiropractors, and osteopathic practitioners within the scope of their practice as defined
by State law; and

WHEREAS, The Social Security Administration defines physician to mean means doctor of
medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental
surgery or dental medicine, doctor of podiatric medicine, or doctor of optometry, or a
chiropractor, legally authorized to practice by a State in which he/she performs this
functions [within given parameters]; and

WHEREAS, Florida, New York, Arizona, Delaware have proposed laws limiting the use of
doctor to persons with a Medical Doctor (MDs) or Doctor of Osteopathic Medicine
(DOs) degree; Six states have passed laws making it a felony for nurse practitioners to
refer to themselves as doctor; Nine states require nurse practitioners to follow their
introduction with a clarifying statement; and

WHEREAS, American Osteopathic Association (AOA) House of Delegates resolution number
H324-A/14 states that the AOA opposes the misuse of the title “doctor” by non-
physician clinicians, in all communications and clinical settings because such use
deceived the public by implying that the non-physician clinician’s education, training, or
credentialing is equivalent to a DO or MD; and

WHEREAS, attempts at promoting mid-level practitioners to independent practice is done
without proper reverence to their important purpose in healthcare, as mid-level support
for physicians; and
WHEREAS, such attempts are often aided by a gross oversimplification of the crucial role belonging to the primary care specialties to which NPs are often assumed to enter; and

WHEREAS, one major justification for the expanded numbers of these practitioners and their scopes of practice is the physician shortage, which is projected that by 2025, demand for physicians will exceed supply by a range of 46,000 to 90,000; and

WHEREAS, we acknowledge that the physician shortage is a real and serious problem on the horizon, but we also cannot afford to sacrifice patient safety or care in the name of momentary expediency; and

WHEREAS, American physicians, Medical Doctors (MDs) or Doctor of Osteopathic Medicine (DOs), undergo one to two and a half additional years of schooling, three additional years of residency training, and fifteen to eighteen thousand more training hours than “Doctors of Nursing Practice”; and

WHEREAS, physicians are trained to direct and lead care, while midlevel providers such as nurse practitioners are not, the DNP degree is administrative in nature and not an advanced clinical degree; and

WHEREAS, there is inadequate evidence to support a transition to midlevel independence; and

WHEREAS, we must applaud and support nurse practitioners stance that their educational model is “patient centered” and “holistic”, we must interject that they are not unique in this viewpoint and reject the accusation that the “medical model” is “disease focused”; and

WHEREAS, continually expanding midlevel provider scope of practice creates an opportunity for a two tiered healthcare system to develop, where rural and underserved populations have limited access to physician providers while those in larger cities have greater access to physician providers, further exacerbating existing disparities in healthcare; and

WHEREAS, the AOA has previously called for a review and validation of nonphysician credentials and standards of care and supported a position that patients should be made clearly aware at all times if they are being treated by a non-physician provider or clinician (H634-A/15); now, therefore be it

RESOLVED, that the American Osteopathic Association supports independent research on the qualification and outcomes of nurse practitioners and other midlevel providers that practice independently.

Explanatory Statement: Submitted by Author
Commonly it is asserted that midlevel providers provide access to rural communities. Firstly, the data shows that midlevel providers such NPs and PAs do not practice in rural areas in a statistically meaningfully different pattern as compared to physicians. Second, it is unjust to reinforce a two-tiered health care system by creating policy that promotes rural community care that is highly dependent on midlevel providers. Instead the policy focus should be to attract and retain physicians in rural areas. To solve a physician shortage, we must focus on physician policy.
References


Background Information: Provided by AOA Staff

Current AOA Policy: H613-A/16 PHYSICIAN SUPPLY IN RURAL, UNDERSERVED UNITED STATES – RECOMMENDATIONS FOR IMPROVING

Prior HOD action on similar or same topic: Policy reaffirmed in 2016.

FISCAL IMPACT: $102,500 in additional expenses over a two (2) year period.
The additional expense would be incurred if AOA sponsors the research. Additional expenses would include: Initiate/Manage Grant Award $1,500; Grant Reviewers $1,000; grant award of $100,000.

ACTION TAKEN _______________________

DATE ______________________________
SUBJECT: SUPPORT THE BOLSTERING OF VETERAN HEALTH ADMINISTRATION RESOURCES THROUGH PROVIDER PAY REFORM

SUBMITTED BY: Student Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, veterans represented 7% (approximately 22.6 million people) of the United States population in 2016; and

WHEREAS, the Veterans Administration (VA) pays private contractors up to $295-300 for each authorization of private care per veteran; and

WHEREAS, existing health services provided directly by the United States Department of Veterans Affairs remain hindered by chronic staffing shortages including 138 of 140 facilities reporting shortages of physicians, especially primary care and psychiatry specialties, and 108 of 140 facilities reporting shortages of nursing occupations; and

WHEREAS, existing health services provided directly by the United States Department of Veterans Affairs remain hindered by uncompetitive pay because of outdated Office of Personnel Management (OPM) classifications preventing the ability to offer more competitive salaries or advancement opportunities; and

WHEREAS, existing health services provided directly by the United States Department of Veterans Affairs remain hindered by personnel management issues including a lack of data on contract physicians and physician trainees resulting in insufficient workforce planning; and

WHEREAS, VA physicians are more knowledgeable about the care for combat injuries, post-traumatic stress disorder, and other health injuries the veteran population faces; and

WHEREAS, American Osteopathic Association (AOA) Resolution H-614-A/18 reaffirms the support of adequate healthcare funding and use of community physicians “when Veterans’ Health Administration facilities cannot provide adequate or timely access”; now, therefore be it

RESOLVED, that the American Osteopathic Association support both staffing management and competitive pay reform at the Veterans’ Health Administration (VHA) to ensure that a full, stable workforces, as budgeted by the Department of Veterans Affairs, is available to meet the health needs of the United States veteran population.
Explanatory Statement: Submitted by Author
Per Resolution H617-A/13, SOMA and the AOA already supports adequate federal funding for health care for veterans at all VHA facilities, as well as federal funding for services from community health providers when VHA facilities are unable to provide adequate or timely access. SOMA and the AOA should advocate for improvements to existing VHA health care services by overhauling staffing data and management; thus, better allowing the VHA to strengthen its current services and provider pool by offering more competitive pay. These issues have been ongoing for years. Not enough has been done to ensure the VHA, which provides care to millions of Americans, keeps a level of modernity adequate enough to meet estimated needs. Addressing these issues would help reduce the need to rely on private health services, which have not met expectations for timeliness.

The intention of this resolution is to provide broad language for SOMA and the AOA to tackle these positions in a manner they find appropriate, without limiting methodology.

References

Background Information: Provided by AOA Staff
Current AOA Policy: H414-A/18 ENVIRONMENTAL HEALTH
Prior HOD action on similar or same topic: Policy reaffirmed in 2018.

FISCAL IMPACT: $0

ACTION TAKEN _____________________
DATE ______________________________
SUBJECT: TELEMEDICINE; REIMBURSEMENT FOR

SUBMITTED BY: New York State Osteopathic Medical Society

REFERRED TO: Ad Hoc Committee

WHEREAS, the world continues to face a global health crisis through the pandemic spread of the corona virus COVID-SARS-19; and

WHEREAS, the health and safety of the peoples throughout the United States is uncertain; and

WHEREAS, in 2018 the Directorate for Global Health Security and Biodefense was shut down thereby limiting the national ability to respond to an emerging infectious disease crisis; and

WHEREAS, school districts throughout the United States have cancelled classes and look to digital platforms for instruction and have revisited and redefined the need for face-to-face time in the classroom, including hybrid versions of in-person and virtual encounters; and

WHEREAS, the number of confirmed cases and deaths in the United States continues to rise; and

WHEREAS, the disease continues to pose a heightened risk to those with immunocompromised and other vulnerable populations including the elderly, those with chronic lung disease, heart disease, cancer, and/or diabetes; and,

WHEREAS, a number of states witnessed their governor declaring public health states of emergency; and

WHEREAS, there has been inconsistent responses in such states as to quarantining measures, prevention techniques including masking and social distancing, and

WHEREAS, currently there are a number of United States’ residents under mandatory quarantine and a far greater number confined to voluntary home isolation; and

WHEREAS, emergency responders have adopted policies that are designed to limit potential spread of the virus and some departments have been directed not to respond to calls from individuals that are experiencing coughs with high fevers and to also cease efforts of life-support or avoid transportation to hospitals for more definitive care if stricken citizens are above a certain age and/or if there was an extended effort; and

WHEREAS, individuals are instructed NOT to go to their physicians’ offices if experiencing cough with fever unless they are in a high risk situation or experiencing shortness of breath when they are told to present to the emergency department of a hospital; and
WHEREAS, individuals ill with other medical conditions may likewise avoid needed in-person medical evaluation and treatment for fear of infection exposure; and

WHEREAS, on March 4, 2020, Congress voted to approve an emergency COVID-SARS-19 spending bill of 8.3 billion dollars to address this growing health crisis; and

WHEREAS, the medical community and community health centers serve as vital role in the maintenance of health and prevention of disease; and

WHEREAS, after 9/11/2001, the country watched as St. Vincent Hospital and Medical Center of New York City took on the role of receiving hospital for 9/11 workers and sustained incredible financial losses from which the hospital did not recover and was forced to close, and identified the particular risk to those who selflessly put themselves and their institution in harm’s way for the good of the peoples in their community; and

WHEREAS, the physicians and other medical providers in the private sector must be enabled to respond to the growing need for medical services including mandatory quarantine and voluntary isolation; and

WHEREAS, technology is available to patients and physicians alike to allow for personalized advice and management through various means including telephonic and video communications (telemedicine); and

WHEREAS, there is acceptance of the utilization telemedicine for geographic areas where access to physicians and other health care providers is not readily accessible; and

WHEREAS, there are means available for these situations and circumstances for these physicians and others to be paid for their services using such telemedicine technology that was enacted on a temporary emergency basis; and

WHEREAS, the COVID-19 pandemic has created situations where persons are instructed to limit personal access to their physicians in an effort to curtail the spread of the contagion; and

WHEREAS, it is essential to provide up-to-the-minute information and medical care as safely and efficiently as possible, and

WHEREAS, the guidelines that determine that combined audio-visual interaction is necessary for one level of payment versus strictly telephonic interaction at another fails to recognize that those who are of a certain age or economic status may not have the means to utilize other than verbal-auditory interaction; and

WHEREAS, Medicare’s coverage of telemedicine is slated to end in the near future if no extension is enacted and especially when the coronavirus no longer poses a public health emergency, and

WHEREAS, private insurers, which followed the federal government’s lead, could revert to paying doctors for virtual visits at a fraction of the cost for traditional visits, if anything at all; now, therefore be it
RESOLVED, that the American Osteopathic Association work with the American Medical Association to advocate for legislation or an Executive Order to mandate that all health insurance plans, including those issued by CMS (Medicaid and Medicare Services) and entities covered under ERISA Law continue to reimburse for such services at a level that is commensurate with a level 4 face-to-face visit; and be it further

RESOLVED that community health centers, physicians and other clinical practitioners be directed to submit claims for services to individuals who have no health insurance to their respective State Offices of Emergency Management so as to utilize emergency funds approved by Congress so as to be able to provide medical care to the widest population of at-risk individuals as possible.

Explanatory Statement: Submitted by Author
None provided.

Background Information: Provided by AOA Staff
Current AOA Policy:
H613-A/16 PHYSICIAN SUPPLY IN RURAL, UNDERSERVED UNITED STATES – RECOMMENDATIONS FOR IMPROVING
H601-A/17 TELEMEDICINE – AOA POLICY ON
H343-A/18 PHYSICIAN PAYMENT FOR ELECTRONIC ADVICE, COUNSELING AND TREATMENT PLANS
H630-A/19 COMMUNICATION TECHNOLOGY-BASED AND REMOTE EVALUATION SERVICES


FISCAL IMPACT: $0

ACTION TAKEN ________________________

DATE ______________________________